AN ACT

ENTITLED, An Act to revise certain provisions concerning the requirements for utilization review and grievances for health carriers.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That § 58-17C-1 be amended to read as follows:

58-17C-1. Terms used in this chapter mean:

(1) "Adverse determination," any of the following:

(a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request by a covered person for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(c) Any prospective review or retrospective review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit;

(2) "Ambulatory review," utilization review of health care services performed or provided in an outpatient setting;

(3) "Authorized representative," a person to whom a covered person has given express written

consent to represent the covered person for purposes of this Act, a person authorized by law to provide substituted consent for a covered person, a family member of the covered person or the covered person's treating health care professional if the covered person is unable to provide consent, or a health care professional if the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional. For any urgent care request, the term includes a health care professional with knowledge of the covered person's medical condition;

(4) "Case management," a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(5) "Certification," a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(6) "Closed plan," a managed care plan or health carrier that requires covered persons to use participating providers under the terms of the managed care plan or health carrier and does not provide any benefits for out-of-network services except for emergency services;

(7) "Concurrent review," utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting;

(8) "Consumer," someone in the general public who may or may not be a covered person or a purchaser of health care, including employers;

(9) "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

(10) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in

a health benefit plan;

(11) "Director," the director of the Division of Insurance;

(12) "Discharge planning," the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(13) "Discounted fee for service," a contractual arrangement between a health carrier and a provider or network of providers under which the provider is compensated in a discounted fashion based upon each service performed and under which there is no contractual responsibility on the part of the provider to manage care, to serve as a gatekeeper or primary care provider, or to provide or assure quality of care. A contract between a provider or network of providers and a health maintenance organization is not a discounted fee for service arrangement;

(14) "Emergency medical condition," the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

(15) "Emergency services," health care items and services furnished or required to evaluate and treat an emergency medical condition;

(16) "Facility," an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings;

(17) "Grievance," a written complaint, or oral complaint if the complaint involves an urgent care request, submitted by or on behalf of a covered person regarding:

(a) Availability, delivery, or quality of health care services;

(b) Claims payment, handling, or reimbursement for health care services;

(c) Any other matter pertaining to the contractual relationship between a covered person and the health carrier.

A request for an expedited review need not be in writing;

(18) "Health benefit plan," a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(19) "Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(20) "Health care provider" or "provider," a health care professional or a facility;

(21) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(22) "Health carrier," an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;

(23) "Health indemnity plan," a health benefit plan that is not a managed care plan or health carrier;

(24) "Intermediary," a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network;

(25) "Managed care contractor," a person who establishes, operates, or maintains a network

of participating providers; or contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan or health carrier;

(26) "Managed care entity," a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization, that operates a managed care plan or a managed care contractor. The term does not include a licensed insurance company unless it contracts with other entities to provide a network of participating providers;

(27) "Managed care plan," a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(28) "Necessary information," includes the results of any face-to-face clinical evaluation or second opinion that may be required;

(29) "Network," the group of participating providers providing services to a health carrier;

(30) "Open plan," a managed care plan or health carrier other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan or health carrier;

(31) "Participating provider," a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments,

or deductibles, directly or indirectly, from the health carrier;

(32) "Prospective review," utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision;

(33) "Quality assessment," the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations;

(34) "Quality improvement," the effort to improve the processes and outcomes related to the provision of care within the health plan;

(35) "Retrospective review," any review of a request for a benefit that is not a prospective review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment;

(36) "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service;

(37) "Secretary," the secretary of the Department of Health;

(38) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, with reasonable medical probability, to result or occur before an individual can be transferred;

(39) "Utilization review," a set of formal techniques used by a managed care plan or utilization review organization to monitor and evaluate the medical necessity, appropriateness, and efficiency of health care services and procedures including techniques such as ambulatory review, prospective review, second opinion, certification, concurrent review, case

management, discharge planning, and retrospective review; and

(40) "Utilization review organization," an entity that conducts utilization review other than a health carrier performing utilization review for its own health benefit plans.

Section 2. That § 58-17C-37 be amended to read as follows:

58-17C-37. A health carrier that requires a request for benefits under the covered person's health plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities, both delegated and nondelegated for:

(1) The filing of benefit requests;

(2) The notification of utilization review and benefit determinations; and

(3) The review of adverse determinations in accordance with §§ 58-17C-58 to 58-17C-63, inclusive.

The program document shall describe the following:

(1) Procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

(2) Data sources and clinical review criteria used in decision-making;

(3) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(4) Data collection processes and analytical methods used in assessing utilization of health care services;

(5) Provisions for assuring confidentiality of clinical and proprietary information;

(6) The organizational structure that periodically assesses utilization review activities and reports to the health carrier's governing body; and

(7) The staff position functionally responsible for day-to-day program management.

A health carrier shall prepare an annual summary report in the format specified of its utilization review program activities and file the report, if requested, with the director and the secretary of the

Department of Health.

Section 3. That § 58-17C-40 be amended to read as follows:

58-17C-40. A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of §§ 58-17C-34 to 58-17C-57, inclusive. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Section 4. That § 58-17C-46 be amended to read as follows:

58-17C-46. When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

Section 5. That § 58-17C-48 be amended to read as follows:

58-17C-48. A health carrier shall maintain written procedures pursuant to this chapter for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified time frames required under this chapter. In the event that a period of time is extended as permitted by this Act, due to a claimant's failure to submit information necessary to decide a prospective, retrospective, or disability claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Section 6. That § 58-17C-49 be amended to read as follows:

58-17C-49. For prospective review determinations, other than allowed by this section, a health carrier shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the carrier certifies the provision of

the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen days after the date the health carrier receives the request. If the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with § 58-17C-52.

The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to this section may be extended once by the health carrier for up to fifteen days, if the health carrier:

(1) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(2) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall specifically describe the required information necessary to complete the request; and give the covered person or, if applicable, the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

If the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request. This notice shall be provided as soon as possible, but in no event later than five days following the date of the failure. The health carrier may provide the notice orally or, if requested by

the covered person or the covered person's authorized representative, in writing. The provisions only apply in a case of failure that is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters and is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which certification is being requested.

Section 7. That § 58-17C-50 be amended to read as follows:

58-17C-50. For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and

(2) The health carrier shall notify the covered person of the adverse determination in accordance with § 58-17C-52 at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to sections 31 to 53, inclusive, of this Act and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated

The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the health carrier with respect to the internal review request made pursuant to sections 31 to 53, inclusive, of this Act.

Section 8. That § 58-17C-51 be amended to read as follows:

58-17C-51. For retrospective review determinations, a health carrier shall make the determination

within a reasonable period of time, but in no event later than thirty days after the date of receiving the benefit request.

In the case of a certification, the health carrier may notify in writing the covered person and the provider rendering the service.

If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with § 58-17C-52. The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to this section may be extended once by the health carrier for up to fifteen days, provided the health carrier:

(1) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(2) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension under this section is necessary due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall specifically describe the required information necessary to complete the request; and give the covered person or, if applicable, the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

Section 9. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

For purposes of calculating the time periods within which a determination is required to be made for prospective and retrospective reviews, the time period within which the determination is required to be made begins on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to § 58-17C-37. If the time period for making the determination for a prospective or retrospective review is extended due to the covered person or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of: the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information or the date on which the specified information was to have been submitted. If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in §§ 58-17C-49 and 58-17C-51, the health carrier may deny the certification of the requested benefit.

Section 10. That § 58-17C-52 be amended to read as follows:

58-17C-52. Any notification of an adverse determination under this section shall, in a manner which is designed to be understood by the covered person, set forth:

(1) The specific reason or reasons for the adverse determination;

(2) A reference to the specific plan provision on which the determination is based;

(3) A description of additional material or information necessary for the covered person to complete the benefit request, including an explanation of why the material or information is necessary to complete the request;

(4) A description of the health carrier's grievance procedures established pursuant to sections 31 to 53, inclusive, of this Act, including time limits applicable to those procedures;

(5) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(6) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(7) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in subdivision (5) of this section; or

(b) The written statement of the scientific or clinical rationale for the adverse determination, as provided in subdivision (6) of this section; and

(8) A statement explaining the right of the covered person, as appropriate, to contact the Division of Insurance at any time for the assistance or, upon completion of the health carrier's grievance procedure process as provided under sections 31 to 53, inclusive, of this Act, to file a civil suit in a court of competent jurisdiction.

A health carrier may provide the notice required under this section in writing or electronically.

Section 11. That § 58-17C-53 be repealed.

Section 12. That § 58-17C-54 be amended to read as follows:

58-17C-54. In the certificate of coverage or member handbook provided to covered persons, a

health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures. A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

Section 13. That § 58-17C-27 be amended to read as follows:

58-17C-27. A health carrier shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed. With respect to care obtained from a noncontracting provider within the service area of a managed care plan, a health carrier shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a participating provider.

A health carrier shall cover emergency services if the plan, acting through a participating provider or other designated representative of the health carrier, has authorized the provision of emergency services.

Section 14. That § 58-17C-28 be amended to read as follows:

58-17C-28. If a participating provider or other designated representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the

covered person's health condition made by the provider of emergency services.

Section 15. That § 58-17C-30 be amended to read as follows:

58-17C-30. For immediately required post-evaluation or post-stabilization services, a health carrier shall provide access to a designated representative twenty-four hours a day, seven days a week, to facilitate review, or otherwise provide coverage with no financial penalty to the covered person.

Section 16. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A health carrier shall establish written procedures in accordance with sections 16 to 24, inclusive, of this Act, for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

Section 17. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two hours after the date of the receipt of the request by the health carrier. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in

accordance with section 24 of this Act.

Section 18. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four hours after receipt of the request.

Section 19. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

If the benefit request involves a prospective review urgent care request, the provisions of section 18 of this Act apply only in the case of a failure that:

(1) Is a communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or provider for which approval is being requested.

Section 20. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

The health carrier shall provide the covered person or, if applicable the covered person's authorized representative a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight hours after the date of notifying the

covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in sections 18 and 19 of this Act.

Section 21. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

The health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight hours after the earlier of:

(1) The health carrier's receipt of the requested specified information; or

(2) The end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested specified information.

If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in section 20 of this Act, the health carrier may deny the certification of the requested benefit. If the health carrier’s determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with § 58-17C-52.

Section 22. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition but in no event more

than twenty-four hours after the date of the health carrier's receipt of the request. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with § 58-17C-52. The provisions of sections 17 to 21, inclusive, of this Act apply to concurrent review urgent care requests.

Section 23. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

For purposes of calculating the time periods within which a determination is required to be made under sections 17 to 22, inclusive, of this Act, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to § 58-17C-37 for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 24. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

If a health carrier's determination with respect to sections 17 to 22, inclusive, of this Act is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with this section. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(1) The specific reason or reasons for the adverse determination;

(2) A reference to the specific plan provisions on which the determination is based;

(3) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(4) A description of the health carrier's internal review procedures established pursuant to sections 31 to 53, inclusive, of this Act, including any time limits applicable to those

procedures;

(5) A description of the health carrier's expedited review procedures established pursuant to sections 16 to 24, inclusive, of this Act;

(6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(7) If the adverse determination is based on a medical necessity or experimental or investigation treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(8) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with subdivision (6) of this section; or

(b) The written statement of the scientific or clinical rationale for the adverse determination in accordance with subdivision (7) of this section; and

(9) A statement explaining the right of the covered person, as appropriate, to contact the Division of Insurance at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under sections 31 to 53, inclusive, of this Act, to file a civil suit in a court of competent jurisdiction.

A health carrier may provide the notice required under this section orally, in writing or electronically. If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

Section 25. That § 58-17C-58 be amended to read as follows:

58-17C-58. Each health carrier shall establish and maintain a grievance system, approved by the director after consultation with the secretary of the Department of Health, which may include an impartial mediation provision, to provide reasonable procedures for the resolution of grievances initiated by any enrollee concerning the provision of health care services. Mediation may be made available to enrollees unless an enrollee elects to litigate a grievance prior to submission to mediation. No medical malpractice damage claim is subject to arbitration under §§ 58-17C-58 to 58-17C-63, inclusive. Each health carrier shall provide that if a grievance is filed which requires a review of services authorized to be provided by a practitioner or if a grievance is filed which requires a review of treatment which has been provided by a practitioner, the review shall include a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Section 26. That § 58-17C-59 be amended to read as follows:

58-17C-59. The health carrier shall maintain records of grievances filed with it and shall submit to the director a summary report at such times and in such format as the director may require. The grievances involving other persons shall be referred to such persons with a copy to the director.

Section 27. That § 58-17C-60 be amended to read as follows:

58-17C-60. The health carrier shall maintain a record of each grievance filed with it for five years, and the director and the secretary of health shall have access to the records.

Section 28. That § 58-17C-61 be repealed.

Section 29. That § 58-17C-62 be repealed.

Section 30. That § 58-17C-20 be amended to read as follows:

58-17C-20. Each managed care contractor, as defined in § 58-17C-1, shall register with the director prior to engaging in any managed care business in this state. The registration is subject to the provisions of §§ 58-17C-64 to 58-17C-68, inclusive, and any applicable rules promulgated pursuant to those sections.

Section 31. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A health carrier shall maintain in a register written records to document all grievances received during a calendar year. A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with sections 34 to 37, inclusive, of this Act, but is not required to be included in the register. A request for an additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to sections 43 to 49, inclusive, of this Act, shall be included in the register. For each grievance the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance;

(2) The date received;

(3) The date of each review or, if applicable, review meeting;

(4) Resolution at each level of the grievance, if applicable;

(5) Date of resolution at each level, if applicable; and

(6) Name of the covered person for whom the grievance was filed.

The register shall be maintained in a manner that is reasonably clear and accessible to the director. A health carrier shall retain the register compiled for a calendar year for five years.

Section 32. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as

follows:

A health carrier shall submit to the director, at least annually, a report in the format specified by the director. The report shall include for each type of health benefit plan offered by the health carrier:

(1) The certificate of compliance required by section 33 of this Act;

(2) The number of covered lives;

(3) The total number of grievances;

(4) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to sections 43 to 49, inclusive, of this Act;

(5) The number of grievances resolved at each level, if applicable, and their resolution;

(6) The number of grievances appealed to the director of which the health carrier has been informed;

(7) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(8) A synopsis of actions being taken to correct problems identified.

Section 33. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

Except as specified of this Act, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in sections 34 to 49, inclusive, of this Act. A health carrier shall file with the director a copy of the procedures required under this section, including all forms used to process requests made pursuant to sections 34 to 49, inclusive, of this Act. Any subsequent material modifications to the documents also shall be filed. The director may disapprove a filing received in accordance with this section that fails to comply with this Act or applicable rules. In addition, a health carrier shall file annually with the director, as part of its annual report required by sections 31 and 32 of this Act, a certificate of compliance stating that the health

carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this Act. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons. The grievance procedure documents shall include a statement of a covered person’s right to contact the Division of Insurance for assistance at any time. The statement shall include the telephone number and address of the Division of Insurance.

Section 34. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to sections 1 to 24, inclusive, of this Act, and to §§ 58-17C-35 to 58-17C-37, inclusive, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination. The health carrier shall provide the covered person with the name, address, and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier. The health carrier shall designate a health care provider or providers who have appropriate training and experience in the field of medicine involved in the medical judgement to evaluate the adverse determination. No health care provider or providers may have been involved in the initial adverse determination. In conducting the review, the reviewer or reviewers shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

Section 35. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

No covered person has the right to attend, or to have a representative in attendance, at the first level review, but the covered person or, if applicable, the covered person's authorized representative is entitled to:

(1) Submit written comments, documents, records, and other material relating to the request for benefits for the review or reviewers to consider when conducting the review; and

(2) Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits. A document, record, or other information shall be considered relevant to a covered person's request for benefits if the document, record, or other information:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;

(c) Demonstrates that, in making the benefit determination, the health carrier, or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(d) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

The health carrier shall make the provisions of this section known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receipt of the grievance.

Section 36. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the following time frames:

(1) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to section 34 of this Act; or

(2) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to section 34 of this Act.

For purposes of calculating the time periods within which a determination is required to be made and notice provided under this section, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 33 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 37. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

The decision issued pursuant to section 36 of this Act shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative and include the following:

(1) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) For a decision involving an adverse determination:

(a) The specific reason or reasons for the adverse determination;

(b) A reference to the specific plan provisions on which the determination is based;

(c) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as the term, relevant, is defined in section 35 of this Act, to the covered person's benefit request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon

request; and

(f) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in subsection (d) of this section; or

(ii) The written statement of the scientific or clinical rationale for the determination, as provided in subsection (e) of this section;

(6) If applicable, a statement indicating:

(a) A description of the process to obtain an additional voluntary review of the first level review decision involving an adverse determination, if the covered person wishes to request a voluntary second level review pursuant to section 36 of this Act;

(b) The written procedures governing the voluntary review, including any required time frame for the review; and

(c) The covered person's right to bring a civil action in a court of competent jurisdiction;

(7) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance director."; and

(8) Notice of the covered person's right to contact the Division of Insurance for assistance at any time, including the telephone number and address of the Division of Insurance.

Section 38. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A health carrier shall establish written procedures for a standard review of a grievance that does

not involve an adverse determination. The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under sections 39 to 42, inclusive, of this Act.

Section 39. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

No covered person has the right to attend, or to have a representative in attendance at the standard review, but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to section 40 of this Act to consider when conducting the review. The health carrier shall make the provisions of this section known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receiving the grievance.

Section 40. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance. The health carrier may not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance. The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address, and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

Section 41. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

The health carrier shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision within twenty working days after the date of receipt of the request for a standard review of a grievance filed pursuant to section 39 of this Act. The time frame

for notification may be varied subject to the following:

(1) Subject to subdivision (2) of this section, if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notifies the covered person or, if applicable, the covered person's authorized representative pursuant to this section within twenty working days, the health carrier may take up to an additional ten working days to issue a written decision; and

(2) A health carrier may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with subdivision (1) of this section, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or, if applicable, the covered person's authorized representative of the extension and the reasons for the delay.

Section 42. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

The written decision issued pursuant to section 41 of this Act shall contain:

(1) The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) If applicable, a statement indicating:

(a) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary second level review

pursuant to section 36 of this Act; and

(b) The written procedures governing the voluntary review, including any required time frame for the review; and

(6) Notice of the covered person's right, at any time, to contact the Division of Insurance, including the telephone number and address of the Division of Insurance.

Section 43. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A health carrier that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons who are dissatisfied with the first level review decision made pursuant to sections 34 to 37, inclusive, of this Act, or who are dissatisfied with the standard review decision made pursuant to sections 38 to 42, inclusive, of this Act, the option to request an additional voluntary review, at which the covered person or the covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier. This section does not apply to health indemnity plans.

A health carrier required by this section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice pursuant to subdivision (6) of section 37 of this Act or subdivision (5) of section 42 of this Act, as appropriate, of the option to file a request with the health carrier for an additional voluntary review of the first level review decision received under sections 34 to 37, inclusive, of this Act, or the standard review decision received under sections 38 to 42, inclusive, of this Act.

Section 44. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

Upon receipt of a request for an additional voluntary review, the health carrier shall send notice to the covered person or, if applicable, the covered person's authorized representative of the covered

person's right to:

(1) Request the opportunity to appear in person before a review panel of the health carrier's designated representatives within five working days after the date of receipt of the notice;

(2) Receive from the health carrier, upon request, copies of all documents, records, and other information that is not confidential or privileged relevant to the covered person's request for benefits;

(3) Present the covered person's case to the review panel;

(4) Submit written comments, documents, records, and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;

(5) If applicable, ask questions of any representative of the health carrier on the review panel; and

(6) Be assisted or represented by an individual of the covered person's choice.

The covered person's right to a fair review may not be made conditional on the covered person's appearance at the review.

Section 45. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

With respect to a voluntary review of a first level review decision made pursuant to sections 34 to 37, inclusive, of this Act, a health carrier shall appoint a review panel to review the request. In conducting the review, the review panel shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to section 44 of this Act, without regard to whether the information was submitted or considered in reaching the first level review decision. The decision of the panel is legally binding on the health carrier.

Except for an individual who was involved with the first level review decision who may be a member of the panel or appear before the panel to present information or answer questions, a majority of the panel shall be comprised of individuals who were not involved in the in the first level review decision made pursuant to sections 34 to 37, inclusive, of this Act.

The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to sections 34 to 37, inclusive, of this Act, are health care professionals who have appropriate expertise. If a reviewing health care professional without the expertise required by this section is not reasonably available and there has been a denial of a health care service, the reviewing health care professional may not:

(1) Be a provider in the covered person's health benefit plan; and

(2) Have a financial interest in the outcome of the review.

Section 46. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

With respect to a voluntary review of a standard review decision made pursuant to sections 38 to 42, inclusive, of this Act, a health carrier shall appoint a review panel to review the request. The decision of the panel is legally binding on the health carrier.

An employee or representative of the health carrier who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions. A majority of the panel shall be comprised of employees or representatives of the health carrier who were not involved in the standard review decision made pursuant to sections 38 to 42, inclusive, of this Act.

Section 47. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

If a covered person or the covered person's authorized representative requests the opportunity

to appear in person before the review panel appointed pursuant to sections 45 and 46 of this Act, the procedures for conducting the review shall include the following provisions:

(1) The review panel shall schedule and hold a review meeting within forty-five working days after the date of receipt of the request;

(2) The covered person or, if applicable, the covered person's authorized representative shall be notified in writing at least fifteen working days in advance of the date of the review meeting;

(3) The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative; and

(4) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative.

In any case in which a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or, if applicable, the covered person's authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology.

If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative at least fifteen working days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own.

The review panel shall issue a written decision, as provided in section 49 of this Act, to the covered person or, if applicable, the covered person's authorized representative within five working days of completing the review meeting.

Section 48. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

If the covered person or, if applicable, the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified timeframe provided under subdivision (1) of section 44 of this Act, the review panel shall issue a decision and notify the covered person or, if applicable, the covered person's authorized representative of the decision, as provided in section 49 of this Act, in writing or electronically, within forty-five working days after the earlier of:

(1) The date the covered person or the covered person's authorized representative notifies the health carrier of the covered person's decision not to request the opportunity to appear in person before the review panel; or

(2) The date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to subdivision (1) of section 44 of this Act.

For purposes of calculating the time periods within which a decision is required to be made and notice provided under this section and section 47 of this Act and this section, the time period shall begin on the date the request for additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 33 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 49. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A decision issued pursuant to sections 47 and 48 of this Act shall include:

(1) The titles and qualifying credentials of the members of the review panel;

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(3) The rationale for the review panel's decision;

(4) A reference to evidence or documentation considered by the review panel in making that decision;

(5) In cases concerning a grievance involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(6) Notice of the covered person's right to contact the Division of Insurance for assistance at any time, including the telephone number and address of the Division of Insurance.

Section 50. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. In addition, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services, but has not been discharged from a facility. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers may not have been involved in making the initial adverse determination.

Section 51. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

Section 52. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with section 53 of this Act as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the date of receipt of the request for the expedited review. If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For purposes of calculating the time periods within which a decision is required to be made under this section, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 33 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 53. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

A notification of a decision under sections 50 to 53, inclusive, of this Act shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth the following:

(1) The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) If the decision involves an adverse determination, the notice shall provide:

(a) The reasons for the adverse determination;

(b) A reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(f) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol, or other similar criterion relied upon

in making the adverse determination as provided in subsection (d) of this section; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination as provided in subsection (e) of this section;

(g) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction; and

(h) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance director."; and

(i) A notice of the covered person's right to contact the Division of Insurance for assistance at any time, including the telephone number and address of the Division of Insurance.

A health carrier may provide the notice required under this section orally, in writing, or electronically. If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the date of the oral notification.

Section 54. The director may promulgate rules, pursuant to chapter 1-26, pertaining to claims for group disability income plans. The rules shall be consistent with applicable federal requirements included in 29 CFR Part 2560.

Section 55. That chapter 58-17C be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, urgent care request, means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Except as provided in subdivision (1), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivisions (1) and (2) shall be treated as an urgent care request.

An Act to revise certain provisions concerning the requirements for utilization review and grievances for health carriers.

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I certify that the attached Act originated in the

HOUSE as Bill No. 1047

_____
Chief Clerk

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_____
Speaker of the House

Attest:

_____
Chief Clerk

_____
President of the Senate

Attest:

_____
Secretary of the Senate

House Bill No. 1047
File No. ____
Chapter No. _____

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Received at this Executive Office this _____ day of _____ ,

20____ at _____ M.

By _____
for the Governor

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The attached Act is hereby approved this _____ day of _____ , A.D., 20___

_____
Governor

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STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State